



PRESCRIBE

Prevent Injury | Change Behaviour

Please complete and return to:

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WORKCOVER, CTP & COMCARE INJURY REHABILITATION REFERRAL

- Work Related Activity Program Functional Exercise Rehabilitation Work Conditioning
 Treatment At The Workplace Gym Based Rehabilitation Home Program

Client Details

First Name:		Surname:	
Address:			
DOB:	Tel (W):	Tel (H):	Mobile:
Claim Number:		Date of Injury:	
Diagnosis:			

Treating Doctor Details (or practice stamp)

Doctors Name:		Practice:	
Address:			
Tel:	Fax:	Email:	
Signature:		Date Signed:	
Medical Certificate Attached: <input type="checkbox"/> Yes <input type="checkbox"/> No			

Insurance Details

Insurer:		Case Manager:	
Tel:	Fax:	Email:	
Approval given for <input type="checkbox"/> Initial Assessment and Report <input type="checkbox"/> 8 session EPMP <input type="checkbox"/> Approval request required			
Signature:		Date Signed:	

Rehabilitation Provider

Company:		Rehabilitation Consultant:	
Tel:	Fax:	Email:	
Current Work Status:	<input type="checkbox"/> Pre injury duties	<input type="checkbox"/> Suitable duties	<input type="checkbox"/> Unfit
Rehabilitation Goal:			